NEBRASKA DEPARTMENT OF INSURANCE
P.O. BOX 82089
LINCOLN, NE 68501-2089

APPLICATION FOR CERTIFICATE TO TRANSACT BUSINESS AS AN INDEPENDENT REVIEW ORGANIZATION PURSUANT TO Neb.Rev.Stat. §44-1312.

1. Name of Applicant: _____

2. Federal I.D. # _____ Date Incorporated _____
D/M/Y

3. Principal Business Address: _____
Street Address

_____
City State Zip Code Telephone #

4. Mailing Address: _____
Street Address

_____
City State Zip Code Telephone #

5. Submitter's name: _____ Email Address: _____

6. Submit with the application documentation that the applicant has received approval or accreditation by a nationally recognized private accrediting entity.

7. Remit with the application a check in the amount of $100.00 in payment of the application fee.

(OVER)

8. List below the principal officers responsible for the operations, management and control of the applicant name herein:

Name _____ Title _____
Business Address: _____
Residence Address: _____
Social Security Number: _____

Name _____ Title _____
Business Address: _____
Residence Address: _____
Social Security Number: _____

Name _____ Title _____
Business Address: _____
Residence Address: _____
Social Security Number: _____

Name _____ Title _____
Business Address: _____
Residence Address: _____
Social Security Number: _____

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

Article 13 – Health Carrier External Review Act:
http://uniweb.legislature.ne.gov/laws/browse-chapters.php?chapter=44